**SUPPORT Balance Billing**

**SB1** *(Sen. Bo Watson – R. Hixson)* / **HB2** *(Rep. Robin Smith – R. Hixon)*

**Why the bill is needed:**

Physicians and other healthcare providers sign contracts to be in health insurance plans’ networks. Since the passage of the Affordable Care Act, some health insurance companies have decided to cut costs (and increase profits) by creating “narrow networks” by contracting with fewer healthcare providers who extend preferential reimbursement rates to those in their network.

While most hospital-based providers want to be in network, the health insurance plans often deny those contracts or offer unacceptably low reimbursement rates. Some patients who schedule care at an in-network hospital may receive services from out-of-network providers as part of the same visit. Patients cannot choose everyone involved in their care team (e.g. radiologists, anesthesiologist, emergency physicians or, pathologists, etc.)

Out-of-network physicians have a right to be reimbursed for their services and are left to bill patients directly for the higher out-of-network charges. Patients get caught in the middle when health insurance plans do not pay the out of network provider’s entire bill and so they receive “surprise medical bills” for the balance amount not paid by insurance.

TMA wants a reasonable solution that shares the burden between providers and insurers, but frees patients from balance and surprise bills for out-of-network care. The federal legislation only applies to those Tennesseans’ enrolled in E.R.I.S.A plans. Therefore, a state solution for Tennesseans’ in the private non-E.R.I.S.A. market and uninsured needs to be implemented. It is important to maintain continuity with the federal solution while making sure that all Tennesseans can be held harmless from surprise or balance medical bills that are no fault of their own.

**This bill closely mirrors recently passed federal legislation.**

**How the bill would work:**

* The initial payment to the provider is chosen by the insurance entity, as it was passed in the federal legislation.
* All amounts are verified by the Tennessee Commissioner of Commerce and Insurance from a database chosen by the state legislature in a bill brought by the Department of Commerce every gubernatorial election cycle.
* There is a provision for an all payers claims database to verify payment rates, but this version of legislation does not hinge on it.
* There is a difference in balance billing and surprise billing. Mainly, surprise billing is a defined term only used in non-elective procedures.
* Either party is allowed to enter into independent dispute resolution which is based on 8 factors:
  + (1) Whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(2) The level of training, education, and experience of the physician;

(3) The physician's usual charge for comparable services with regard to patients covered by health carrier networks in which the physician is not participating;

(4) The circumstances and complexity of the particular case, including time and place of the service;

(5) Individual patient characteristics;

(6) The usual and customary rate of the service;

(7) The fiftieth percentile of rates for the service or supply paid to participating physicians in the same or similar;

(8) The recent history of network contracting between the parties.

* The independent dispute resolution entity shall not consider:

(1) Any benchmarking database that includes Medicare or Medicaid reimbursement rates; or

(2) Medicare or Medicaid reimbursement rates.

* The legislation would only apply to services rendered by physicians who are out of network, and by definition, does not include hospitals.